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The Philips Healthcare *"Reimbursement Simplified"* Webinar Series

NOVEMBER 2010

INTRODUCTION AND GUIDE

When the new health reform law was enacted in March, 2010, it introduced sweeping changes throughout the U.S. health care system. Although most of the attention given to the new law has focused on broad issues such as mandated insurance coverage or health insurance market reforms, the law also introduced significant changes in how Medicare pays for services.

Many of these Medicare provisions—which range from demonstration projects to actual reimbursement changes that begin as soon as 2012—are designed to better align payment incentives with quality outcomes. What that means in real world terms is that Medicare will increasingly use the level of payment for an intervention or how the payment is structured to encourage the provider to offer care that leads to better and measurable outcomes for patients.

The law includes many of these quality-based reimbursement changes or demonstration projects that explore them. Here are several key ones:

- Basing payment rates upon how well providers achieve well-established quality metrics, such as reducing post-surgical infections or reducing hospital-acquired conditions.
- Paying integrated care providers a single bundled rate to cover all the care a patient needs during a set period of time, such as a month or year.
- Allowing patients to designate a specific physician or other provider who would coordinate all care the patient receives across the spectrum of providers or locations.
- Extending the episode of care to encompass post-discharge outcomes, including preventable re-admissions.

During the past two years, Philips Healthcare's "Reimbursement Simplified" Webinar Series has featured webinars on many of the payment approaches and incentives that are now incorporated into the health reform system. These sessions have drawn experts from such fields as health policy, government, insurance, health care delivery, and consulting who have explained the underlying forces driving major health reform in the US as well as the primary policy tools for improving clinical quality, outcomes, and cost-effectiveness.

This e-book provides a handy summary of these webinar discussions. We have compiled the sessions into some of the key themes and provisions of health reform. Each section of the e-book is based on a selection of slides from webinar speakers and links electronically to the original webinars in case you want more detail or a sense of the complete discussion. The original webinars are available on Philips Healthcare's reimbursement site, www.philips.com/reimbursement.

Global Payments: Panacea for Payment Reform?

July 29, 2009

Ann Edwards
Director, Health Industries Advisory Practice, PricewaterhouseCoopers

Dolores Mitchell
Executive Director, Group Insurance Commission, Commonwealth of Massachusetts

Nancy Foster
Vice President of Quality, American Hospital Association

Laurel Sweeney, Moderator
Senior Director, Global Reimbursement Policy, Philips Healthcare

To view the webinar visit:
http://www.healthcare.philips.com/us_en/support/Reimbursement/Education/archive.wpd

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WEBINAR OVERVIEW

With health spending rising at an unsustainable rate, there is little argument that payment reform is essential. Moving from a fee-for-service system to global payments was the subject of much debate on Capitol Hill and in the states. In the l990s, capitation—a fixed prospective payment to a health care delivery organization—was tried, and largely rejected. This experience left payers, providers and patients understandably cautious with payment models such as "global payments." How are the payment reforms in the new health reform bill different from the capitation debacle of the '90s? Can providers minimize financial risk while still maintaining quality care under a new system? Will global payments produce better outcomes? What lessons can we learn from the '90s as health reform implementation begins.

*According to **Ann Edwards**, we all recognize the problems:*

- The economy will require that we address health care costs, which are at 16% of GDP and rising
- Health industry leaders agree that something needs to be done to solve the trio of problems in access, quality and affordability (but disagree over what should be done)
- The President has promised to do something major to fix the problems. (However: The President faces tight budgetary constraints)
- Related to the national deficit, national spending priorities, and slow economic recovery

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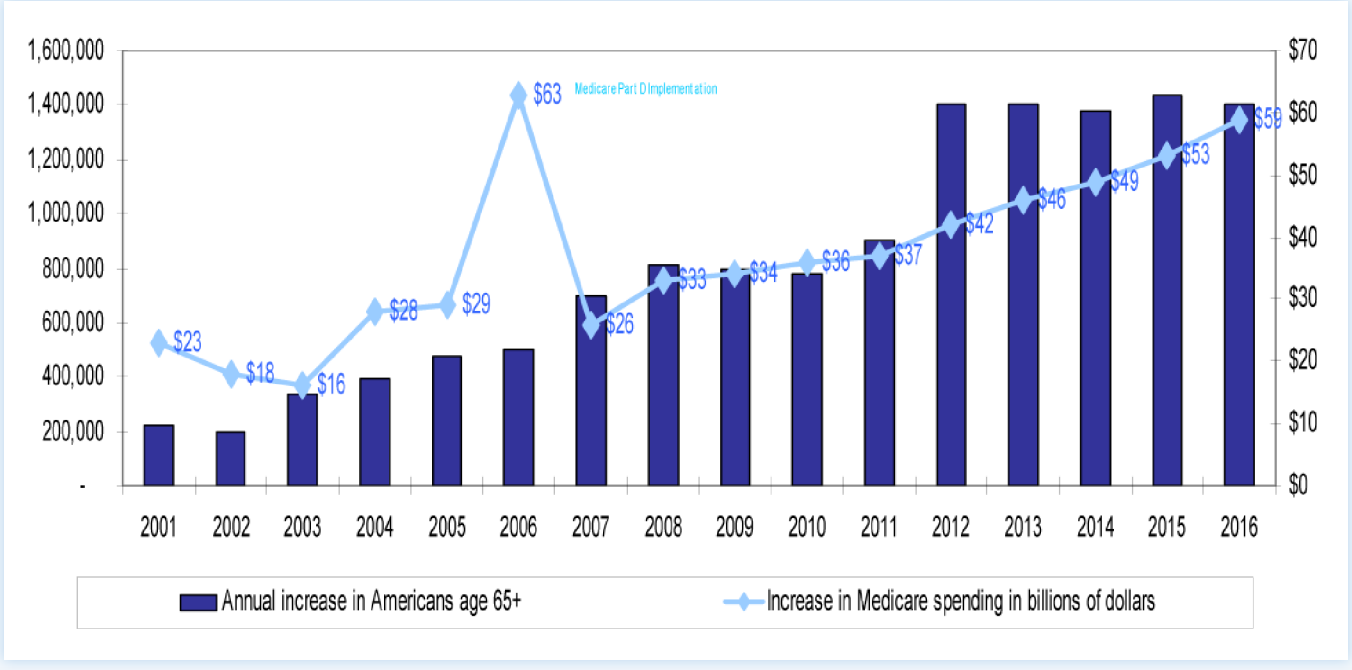
▼ **Projected annual increase in the number of Americans 65+ and changes in Medicare spending billions (2001-2016)**



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Bundled Payments

Global Payment Definition - all services and fees will be included. One payment that manages the patient across the health care delivery system. MedPAC March 5, 2008 meeting:

- There will be a two year period of confidential information dissemination to hospitals and doctors advising them of how much they are spending now on selected episodes and how their spending compares with others.
- Hospitalization will include the actual stay plus 30 days after discharge (to encourage providers to be mindful of patient care needs after discharge).
- After that, targeted global payments would be established based on benchmarks set by the costs of efficient providers.
- Eventually, payments to low-cost providers would be increased and high-cost providers would be penalized.

Implementation Issues

- Require single recipient of payment
- Hospitals traditionally have stronger infrastructures to receive and administer payments.
- How will we contract between provider and physician?: Individually, Groups, or Globally
- What are the downstream effects of payment reform?
    * Physician employment?
    * Reduced physician owned ancillaries?
    * Outpatient hospital services driven back to the hospital?
    * Formal alignment models?

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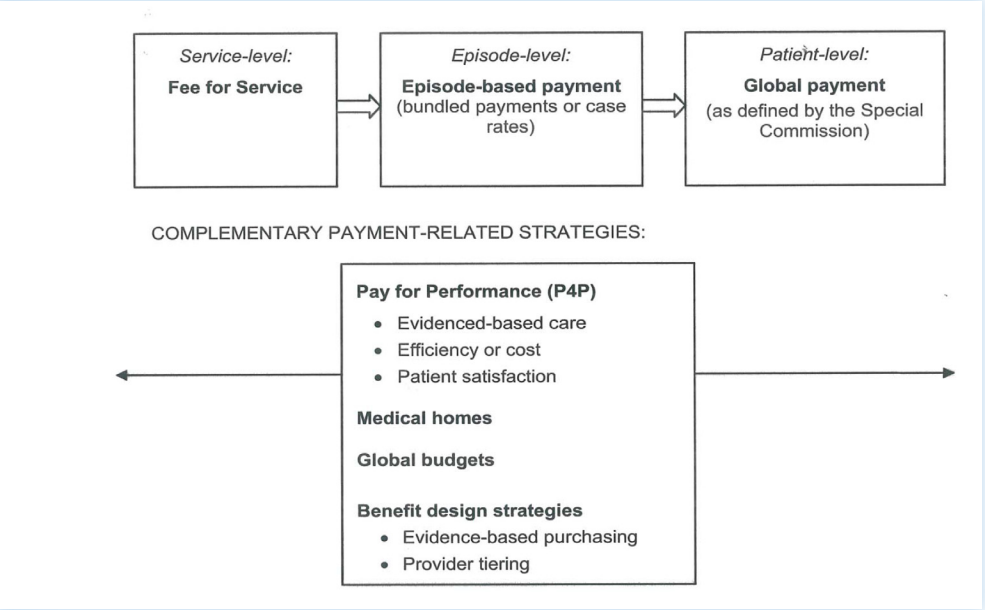
***Delores Mitchell**, looked at various payment options:*



Global Payment:

A provider group or network ("Accountable Care Organization") receives fixed dollar payments per month for each patient with a primary care MD within the ACO.

- ACO accepts financial risk. Providers are responsible for performance risk, i.e., the risk they can control.
- Carrier or self-insured employer holds the "insurance risk" for the risk that the providers cannot control.
- Risk-adjustment and socio-economic adjustment, with option also for risk corridors, stop loss and reinsurance.
- Global payment is also adjusted to reflect performance on access and quality measures to ensure that ACOs don't succeed by stinting.
- Addresses the fee-for-service "volume incentive" that rewards delivery of increased volumes of services, and especially of services with high profit margins.

How do we Transition to and Sustain a Global Payment Model?

- Shared savings
- Formation of Accountable Care Organizations (ACOs)
- Support for ACOs
- Oversight
- Development of global payments
- Transition milestones
- Monitoring
- Complementary strategies

Difference from Prior Capitation Models

- Careful transition period with
- Extensive provider supports
- Robust monitoring activities to guard against unintended consequences
- Linked to performance measures with emphasis on patient-centered care
- Improved risk adjustment models
- Health information technology infrastructure support

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***Nancy Foster**, depicted "the Coming Era" in this way:*

Build the Infrastructure

- Link information systems to reduce chance of error, improve decision-making
- Better serve patients and their families pre- and post-discharge
- Decrease infections/other complications

Track the Outcomes

- Reduced readmissions

More Risk

- Bundled payments for hospitals and
  - Doctors
  - Post acute care providers
  - All caregivers in entire episodes of care
- Accountable Care Organizations
  - Virtual or real
  - "Warranty" care
- Value Based Purchasing linking quality performance to fiscal performance

More Transparency

- Inpatient and outpatient quality data
- Physician quality data
- Ambulatory surgical center data
- Pricing
- Adverse events
- Executive compensation
- Outcomes
- Patient perceptions
- Information technology implementation

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What Will Be Expected of Hospitals?

- Better outcomes
- Greater efficiency
- Less chaos and confusion

What Will Hospitals Expect?

- Recognition of differences in patient circumstances
- Elimination of regulatory impediments
- Less chaos and confusion
- Time–at least a little

What do Hospitals Anticipate?

- Fast paced change
- Those who do good things for patients will do better financially
- Incentives will be better aligned across providers
- Efficiencies will be required

PRESENTER BIOS

Ann Edwards is a Director in the Health Industries Advisory Practice of PricewaterhouseCoopers. She has over 25 years of health care administrative leadership, operational and consulting experience. Her experience includes the areas of operations improvement in a variety of health care provider settings, including academic medical centers, community hospitals, physician practices and ambulatory care services. In addition, she has led business development projects and advised on strategic planning efforts for a variety of health care settings.

Dolores L. Mitchell is the Executive Director of the Group Massachusetts Insurance Commission, the agency that provides life, health, disability and dental and vision services to more than 300,000 state and certain municipalities, employees, retirees and their dependents. She has been in that position since 1987, serving in the administrations of Governors Dukakis, Weld, Cellucci, Swift, Romney, and now Governor Patrick.

Mrs. Mitchell is a member of a number of professional and community organizations, including the Massachusetts Health Data Consortium, of which she is a Director, the Greater Boston Big Sister Association, of which she is Board Chairman, the Massachusetts Coalition for the Prevention of Medical Errors, the Massachusetts Health Council, the Leadership Group of the EHealth Initiative, and the Mass E-Health Collaborative of which she is a Director. Most recently, she became a member of the governing board of the new Massachusetts health reform law, the Connector Authority, and its companion organization, the Quality and Cost Council and last year was elected to the board of the National Committee for Quality Assurance (NCQA), the Hospital Quality Alliance (HQA), Disclosure Group and the eHealth Initiative and eHealth Initiative Foundation.

Nancy Foster is the Vice President for Quality and Patient Safety Policy at the American Hospital Association (AHA). In this role, she is the AHA's point person for the Hospital Quality Alliance, which is a public-private effort to provide information to consumers on the quality of care in American hospitals. Nancy represents the AHA at the National Quality Forum, is the liaison to the Joint Commission's Board, co-chairs the National Priority Partners' care coordination work group, and represents hospital perspectives at many national meetings. She provides advice to hospitals and public policy makers on opportunities to improve patient safety and quality.

Prior to joining the AHA, Nancy was the Coordinator for Quality Activities at the Agency for Healthcare Research and Quality (AHRQ). In this role, she was the principal staff person for the Quality Interagency Coordination Task Force, which brought Federal agencies with health care responsibilities together to jointly engage in projects to improve quality and safety. She also led the development of patient safety research agenda for AHRQ and managed a portfolio of quality and safety research grants in excess of $10 million.

Reimbursement & Quality under Health Reform

January 28, 2010

Gail Wilensky, PhD
Former Administrator, Centers for Medicare & Medicaid Services; Senior Fellow, Project HOPE

Murray Ross, PhD
Vice President, Kaiser Foundation Health Plan; Former Executive Director, Medicare Payment Advisory Commission

Alex Calcagno
Director of Federal Relations, Massachusetts Medical Society

Laurel Sweeney, Moderator
Senior Director, Global Reimbursement Policy, Philips Healthcare

To view the webinar visit:
http://www.healthcare.philips.com/us_en/support/Reimbursement/Education/archive.wpd

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WEBINAR OVERVIEW

The Affordable Care Act became law on March 23, 2010. Two months prior to the passage of health reform, which represents some of the most sweeping changes ever in health delivery, Philips Healthcare held a webinar to gain insight from experts in the field on how health reform might affect reimbursement for hospitals, physicians, and other providers. The panelists addressed three critical questions:

1. What are the new reimbursement policies under consideration in the health reform legislation?
2. What new measures will be used to evaluate performance and how do these link to reimbursement?
3. What are the keys to success in this environment?

In setting up the conversation, ***Gail Wilensky*** *pointed out the numerous problems and challenges that health reform sought to correct:*

- Unsustainable spending growth
- Problems with patient safety
- Problems with quality/clinical appropriateness
- Number of uninsured

While the current focus had been on expanding health insurance coverage

- Insurance reforms
- Individual mandates
- Subsidies and Medicaid expansions and
- Insurance exchanges

There had been limited delivery system reforms

- This is the *hard* part; and will take a lot *longer* to implement
- Lots of pilots - accountable care organizations; payment bundling
- Some value-based purchasing proposal plans to Congress in 2011 and 2012
- CMS Innovation Center

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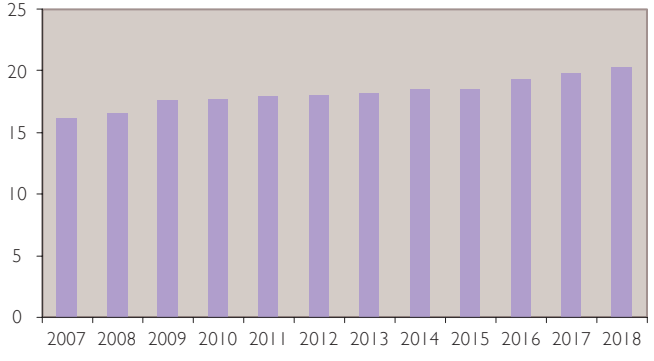
***Murray Ross** continued with an overview of what made health reform so complicated:*

The technical fixes are not easy

- Not everyone agrees on the problem to be solved
- Trying to create in policy what does not exist in nature

Promises come back to haunt you

- If you like the plan you've got, you can keep it
- No tax increases for [fill in your favorite people]
- Will not increase the deficit by $1



▲ National Health Spending as Percent of GDP, 2007-2018

Cultural/social issues invariably come up

Goring oxen not what political system does well

- Excess costs are somebody's income (and they know it)
- Everyone hates change

Why something had to be done

- The imperative for cost control strengthens
  - Health care won't reform itself
  - We'll add another Medicare & Medicaid in the next decade
  - Labor market pressure won't end soon
  - First baby-boomers hit Medicare in 338 days
  - Hospital Trust Fund insolvent in 2017
  - Can't spend money twice
  - China will eventually close our credit line
- The imperative for better value—cannot keep:
  - Covering drugs/devices/services in the absence of evidence
  - Paying without regard to the outcome we want
  - Sustaining health care as a cottage industry

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What's Next

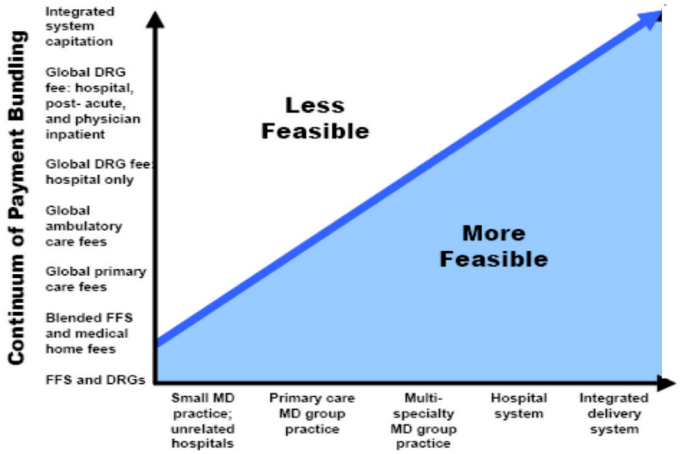
- Continued pressure to generate better evidence
  - Hard times toughen purchasers' resolve
  - Political agreement (ARRA $$ for comparative effectiveness)
  - Health information technology—better data, better support
- Progression of payment reform—public and private
  - Payment for information
  - Pay for quality
  - Bundling
- Delivery system reform (a long-term project)
  - Accountable care organizations, medical homes
  - Health information technology enabling linkage

We Still Need Physician Payment Reform

- Latest patch expires in February; at least one more is in our future
- Difficult to reform health care without reforming how physicians are paid
- Current system is fundamentally broken
  - paid more to do more/more complex
  - no reward for good outcomes, conservative practices

The payment/delivery system reform nexus

▼ Interrelation of organization and payment.



Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).

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***Alex Calcagno** asked, and answered -*
what needs to be done on Physician Payment Reform:

Goal: Replace the Current Physician Payment Formula with a Rationale and Equitable Formula

- SGR: Sustainable Growth Rate – Instituted in 1998
- Significant cuts last 8 years: stopped by Congress
- 21% cut in 2010
    - Two Major Challenges: Eliminating debt from previous SGR "fixes" and funding for new payment formula

Accountable Care Organizations (ACO's)

- Demonstration grants to test new models of care including global payments
- Must be voluntary, tested
- One size does not fit all: small practices
- Critical that infrastructure be in place to be successful
- Antitrust reform?? – missing element
- MA focus right now

Defensive Medicine

- Grants to states to explore alternatives to current tort system:
    - Includes Apology, Medical Courts, Early Offer, Arbitration
    - MMS study
- Does not apply to caps
- President already authorized $50 million in grants

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PRESENTER BIOS

Gail Wilensky, PhD, is an economist and a Senior Fellow at Project HOPE, an international health education foundation. She serves as a trustee of the Combined Benefits Fund of the United Mine Workers of America and the National Opinion Research Center, is on the Board of Regents of the Uniformed Services University of the Health Sciences and the visiting committee of the Harvard Medical School. She recently served as president of the Defense Health Board, a federal advisory board to the Secretary of Defense and chaired their health care subcommittee, was a commissioner on the World Health Organization's Commission on the Social Determinants of Health and co-chaired the Department of Defense Task Force on the Future of Military Health Care.

From 1990 to 1992, she was Administrator of the Health Care Financing Administration (now CMS). She also served as Deputy Assistant to President (GHW) Bush for Policy Development. From 1997-2001, she chaired the Medicare Payment Advisory Commission. From 2001 to 2003, she co-chaired the President's Task Force to Improve Health Care delivery for Our Nation's Veterans. In 2007, she was a commissioner on the President's Commission on care for America's Returning Wounded Warriors.

Murray N. Ross, PhD, is Vice President, Kaiser Foundation Health Plan, and Director of the Kaiser Permanente Institute for Health Policy in Oakland, California. His current work focuses on delivery system reform and improving the evidence base for health decision making.

Before joining Kaiser Permanente in 2002, Dr. Ross was an advisor to the United States Congress. He served almost five years as the Executive Director of the Medicare Payment Advisory Commission, a nonpartisan agency charged with making recommendations on Medicare policy issues to the Congress. Previously, he spent nine years at the Congressional Budget Office, lastly heading up the group charged with assessing the budgetary impact of legislative proposals affecting Medicare and Medicaid.

Alex Calcagno is Director of Federal and Community Relations for the Massachusetts Medical Society. She is responsible for advocating the Medical Society's position before the United States Congress, White House and Executive Agencies. Prior to coming to the Medical Society, Alex was Assistant Director of the American Academy of Pediatrics Office of Government Liaison in Washington, DC where she lobbied for children's health care for 10 years. Her first entry into the political arena was as Assistant Press Secretary for United States Representative M. Caldwell Butler.

Quality, Health Reform & the Bottom Line: How Quality-Focused Payment Changes under Health Reform Will Affect Hospitals

October 27, 2010

Beth Roberts
Partner, Hogan Lovells

Brent James, MD, MStat
Executive Director and Chief Quality Officer, Institute for Health Care Delivery Research, Intermountain Healthcare

Ann Edwards
Director, Health Industries Advisory Practice, PriceWaterhouseCoopers

Laurel Sweeney, Moderator
Senior Director, Global Reimbursement Policy, Philips Healthcare

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WEBINAR OVERVIEW

Health reform was passed to not only provide insurance to those without but to "bend the cost curve" in such a way as to achieve savings while improving quality across the health system. One of the most significant provisions in the new law, value-based purchasing, ties Medicare reimbursement to process and outcome measures, marking the first time Medicare is paying for outcomes. Other provisions also tie payment directly to quality: preventable readmissions, preventable hospital-acquired conditions, and a payment bundling pilot program.

This webinar's panel of experts provided: a clear sense of what the new law requires, an example of how one provider addressed these pressures, and techniques and strategies for hospitals to prepare in this new environment.

***Beth Roberts** opened the discussion by reminding the audience that the Patient Protection and Affordable Care Act (ACA) aims to:*

- Incentivize providers to provide more efficient and higher quality care
- Establish systems that encourage coordination of patient care
- Improve payment accuracy under federal health care programs
- Reduce health care fraud and abuse

ACA seeks to achieve this by:

- Making payment changes
- Creating demonstration and pilot programs
- Establishing entities charged with developing innovative payment models

Hospital Payment Adjustments

- ACA reduces the market basket updates for Medicare payments in fiscal years 2010 through 2019
- ACA also calls for a productivity adjustment to the market basket update beginning in 2010

Health Care-Acquired Conditions (HCAs)

- Under the Act, Medicare IPPS payments will be reduced with respect to discharges from IPPS hospitals in the top quartile of national, risk-adjusted HAC rates
- The Centers for Medicare and Medicaid Services (CMS) is also required to conduct a study regarding the expansion of this policy to payments made to other facilities under Medicare

Preventable Readmissions

- Preventing hospital readmissions is viewed as a way to cut costs
- For hospital discharges occurring on or after October 1, 2012, CMS is required to reduce certain base operating Medicare Severity Diagnosis Related Group (MS-DRG) payment amounts by an adjustment factor based on the number of excess readmissions from the hospital
- What constitutes "excess readmissions" will be determined by CMS

Hospital Value Based Purchasing

- CMS is required to establish a hospital value-based purchasing program applicable to payments for discharges occurring on or after October 1, 2012
- Under the program, the MS-DRG for IPPS hospitals will be reduced by a percentage specified in the statute, but hospitals that meet performance standards on certain RHQDAPU and efficiency measures will receive a bonus payment
- The performance standards for 2013 must cover certain conditions including:
    * Acute myocardial infarction
    * Heart failure
    * Pneumonia
    * Surgeries
    * Health care-associated infections

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Development of Innovative Payment Models

- ACA creates a Center for Medicare and Medicaid Innovation (CMI) to test and implement payment methods that improve the delivery of care and reduce costs
- ACA also creates a number of demonstration programs to delivery models that bundle payments and otherwise incentivize both the delivery of higher quality of care and the coordination of patient care, such as:
    * Accountable Care Organizations
    * National pilot program on payment bundling

Center for Medicare and Medicaid Innovation (CMI)

- CMI must be created by January 1, 2011 to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP, while preserving the quality of care.
- Models will be selected by HHS, with preference given to models that address populations with deficits in care that lead to poor clinical outcomes and potentially avoidable expenditures.
- Models to be tested:
    * Varying payment to physicians who order advanced diagnostic imaging services according to the adherence to appropriateness criteria
    * Medical homes
    * Coordinated care
    * Alternative payment mechanisms
    * HIT
    * Medication management
    * Patient education
    * Integrated care for dual-eligibles
    * Care for cancer patients
    * Post-acute care
    * Chronic care management
    * Collaboration among mixed provider types

Accountable Care Organizations (ACOs)

- Under the Medicare Shared Saving Program, effective January 1, 2012, certain providers of services and suppliers that have established a mechanism for shared governance may work together in partnership with or under a joint venture arrangement with a hospital to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO.
- Under the program, ACOs will still be reimbursed under fee-for-service (or other payment models determined appropriate by HHS), but those ACOs that meet quality performance standards set by the Secretary may also receive shared savings up to an amount to be determined by the Secretary.

National Pilot Program on Payment Bundling

- The Medicare National Pilot Program on Payment Bundling, effective January 1, 2013, will hold participating providers and suppliers jointly accountable for an episode of care around a hospitalization and will provide them with incentives to coordinate patient care.
- The program will last for a 5-year period unless extended by the Secretary.

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*Next, **Brent James** reviewed how quality-focused payment changes under health reform will affect hospitals*

Patient Safety: Background Facts

Initial estimates of injury rates were conservative—*about 25% of hospital inpatients suffer one or more care-associated injuries*

Roughly half are preventable—*quality waste: "do it right the first time;" "move upstream"*

Significant resource consumption to treat preventable injuries—*hospital operating costs*

Potential legal exposure—*issues around public perception of the hospital*

CMS "pay for quality" initiatives

Quality metrics—*mandatory data submissions; differential payment based on rankings*

Patient injuries—*"never" events*

Provider at risk payment—*ACOs; bundled payment*

Safer Care is Possible

- IHI bundles for
  - Central line blood stream infection
  - Ventilator-acquired pneumonia
- ACS NSQIP initiative for surgical complications (e.g., infections)
- WHO surgery checklist
- ADE reductions

ACOs/AMHs

- Various sophisticated forms of capitation (provider at financial risk but with better data systems and better risk adjustment)
- Represent "managed care at the bedside"
- More than 80% of cost saving opportunities live on the clinical side

Ann Edwards *offered 4 key questions, and strategies, for hospitals to consider when seeking ways to improve their delivery of cost effective, high quality care*

How do you measure up?

- Quality and efficiency will increasingly impact how providers are paid
- Focus is on all the additional ways providers will be evaluated, compared, and reported
- Providers should know how they will be measured and what they can do to improve the results

How do you think outside the box?

- A provider's ability to manage across the entire continuum of care will increasingly impact its viability
- Hospitals and health systems need to consider the impact of the legislation on the broader health delivery system
- Providers should focus on defining and delivering cost effective and high quality care

How do you thrive on governmental reimbursement?

- More revenue under health reform, but increasingly restrictive government sector payments bring continued challenges to providers
- An ever increasing percentage of patients paid under governmental rates; over next 10 years > 10% increase could be expected
- Cost containment and efficient delivery of services will be needed for success

How do you ensure you are doing the right thing?

- Health reform increases our regulatory environment but also puts heightened focus on community needs and tax-exempt status
- Expansion in regulatory environment of health care and more public disclosure means risks associated with compliance is increasing
- Compliance should be treated as a fundamental part of doing business, not as an independent discrete function

PRESENTER BIOS

Beth L. Roberts, JD is a Partner with the law firm Hogan Lovells where she assists clients with optimizing the value of their innovative medical technologies. She helps clients navigate the complex coding, coverage, and reimbursement challenges faced by their new technologies. Beth counsels clients on Medicare and other health care compliance issues and lobbies the US Congress and regulatory agencies on her clients' behalf. Prior to joining Hogan & Hartson, Beth served as a judicial clerk for the Honorable John Ferren on the District of Columbia Court of Appeals. While attending law school, Beth served as administrative editor of the Texas International Law Journal.

Brent C. James, MD, MStat is known internationally for his work in clinical quality improvement, patient safety, and the infrastructure that underlies successful improvement efforts. Dr. James is the Chief Quality Officer and Executive Director of the Institute for Health Care Delivery Research at Intermountain Healthcare. Before coming to Intermountain, Dr. James was an Assistant Professor in the Department of Biostatistics at the Harvard School of Public Health, providing statistical support for the Eastern Cooperative Oncology Group and staffing the American College of Surgeons' Commission on Cancer. Dr. James is a member of the National Academy of Science's Institute of Medicine and participated in many of that organization's seminal woks on quality and patient safety. He holds faculty appointments at the University of Utah School of Medicine, the Harvard School of Public Health and the University of Sydney, Australia, School of Public Health.

Ann Edwards is a Director in the Health Industries Advisory Practice of PriceWaterhouseCoopers. She has over 25 years of health care administrative leadership, operational and consulting experience. Her experience includes the areas of operations improvement in a variety of health care provider settings, including academic medical centers, community hospitals, physician practices and ambulatory care services. In addition, she has led business development projects and advised on strategic planning efforts for a variety of health care settings.

The Medical Home: A Model for Health Reform?

February 17, 2009

James F. Coan
Project Officer, Medicare Medical Home Demonstration, Centers for Medicare & Medicaid Services

Chad Boult, MD, MPH, MBA
Professor of Public Health, Director, Lipitz Center for Integrated Health Care, Department of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University

Barbara Walters, DO, MBA
Senior Medical Director, Dartmouth-Hitchcock Medical Center

Laurel Sweeney, Moderator
Senior Director, Global Reimbursement Policy, Philips Healthcare

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WEBINAR OVERVIEW

One of the hottest concepts for addressing health cost and quality problems in the US is known as the "medical home," or "health home." This isn't a specific location of care, but an approach to providing comprehensive primary care in which a patient's primary physician coordinates all of the care the patient receives.

Many policymakers are taking a close look at this concept—along with all of its various definitions and models. Congress has directed Medicare to begin a demonstration project, and a variety of health providers and payers are exploring it as well.

This webinar took an in-depth look at two programs underway – the Medicare Medical Home Demonstration and the "Patient Centered Medical Home" pilot program recently launched by Dartmouth Hitchcock Medical Center and Cigna Healthcare.

***James Coan**, provided an overview of the Medicare Medical Home Demonstration:*

Demonstration Specifics

- 3-Year demonstration
- No more than 8 states
- Physician-based practices
- High-need population
- Individuals with chronic illnesses that require regular medical monitoring, advising, or treatment

The two main parts of the Medical Home are the practice and the physician.

Medical Home is a term that applies to a physician-based practice

- Has necessary capabilities in place
- Practice culture supports Medical Home type care
- Is committed to coordinating/managing all patient care

There are two tiers of a medical home

Tier 1: "Typical" Medical Home services (14 required capabilities, ie, use integrated care plan, use data to identify/track patients)

Tier 2: "Enhanced" medical Typical Tier home services (all Tier 1 requirements plus four more, including: Electronic Health Record)

- Both are fully functional and qualified
- Practices that start as Tier 1 can later apply for Tier 2

Which Practices Are Qualified?

- Physician-based practices
- First point of contact and main source of primary care
- Must be able to provide Medical Home services
    * Oversee development and implementation of plan of care
    * Use evidence-based medicine and decision-support tools
    * Use health information technology to monitor and track health status of patients
    * Encourage patient self-management

Participating Physicians

- Work within the Medical Home practice structure
- Provide health care management services beyond regular medical care
- "Quarterback" of the health care management team

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Physician Responsibilities - Each Physician in the Medical Home is Expected to Provide Specific Services to Each Patient as Necessary

- Provide ongoing support, oversight, and guidance through a health care team
- Provide integrated coherent planning for ongoing medical care including communication and coordination with other physicians and health care professionals furnishing care
- Provide development and/or revision of documented care plans, including integration of new information and/or adjustment of medical therapy
- Track hospital, and other facility admissions, with appropriate follow-up after discharge
- Oversee and track medication changes initiated by pharmacy benefit plans
- Provide reconciliation of medications to avoid interactions or duplications
- Review medication changes occurring outside of their own E/M visit, including all prescriptions and related communication with other physicians and health care professionals
- Review reports of patient status from other physicians or health care professionals
- Review results of laboratory and other studies
- Monitor staff to ensure the use of evidence-based medicine and clinical decision support tools to facilitate diagnostic test tracking, pre-visit planning, and after-visit/test follow-up
- Maintain communication (including telephone calls, secure web sites, etc.) with the patient, family, and caregivers for purposes of assessment or care decisions
- Use patient self-management plan (including end-of life planning, home monitoring)

Benefits to Practices Include

- Care management fee (in addition to activities already reimbursed by Medicare)
- Share in savings
- Ability to provide better quality care to patients
- Improved practice workflow
- Improved job satisfaction

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***Chad Boult**, described the technical assistance he and his colleagues from Johns Hopkins Bloomberg School of Public Health are providing CMS for the Medicare Medical Home Demonstration Project:*

- Guided Care implementation manual
- On-line course for Guided Care nurses
- On-line course for physicians
- Guidance in selecting health information technology
- Online practice self-assessment ("MHIQ")
- Webinars, learning collaboratives, networks
- Information by Internet and telephone
- Consultation

***Barbara Walters**, then described the Pay for Performance at Dartmouth-Hitchcock, "Your Medical Home":*

Most Important Clinical Interventions

- ICD 9 coding training
- Transform the role of the RN – health coaches, and pre-visit planning
- Registry development
- Post discharge phone call

Adopted Reimbursement Principles - Reimbursement Should:

- Reflect the value of non-face time
- Pay for care coordination
- Support adoption and use of health information technology for QI
- Support enhanced communication such as secure email and telephone consultation
- Allow for separate fee-for-service visit payment
- Recognize case mix differences in patient population
- Allow for physicians to share in savings from reduced hospitalizations
- Allow for additional payments for achieving measurable quality improvements

Payment Reform

Three Tiered Payment System

PRESENTER BIOS

James F. Coan, is a Social Science Research Analyst in the Demonstrations Program Group of the Office of Research Development and Information in the Centers for Medicare and Medicaid Services. The majority of Jim's experience, however, comes from the world of public health as a Senior Public Health Advisor for 22 years with the Centers for Disease Control and Prevention. During that time Jim has worked extensively in the areas of communicable disease prevention, vaccine preventable diseases, and chronic disease prevention at the local, state, and national levels. He also has worked abroad in Southeast Asia with Indochinese refugees.

Throughout his career, Jim has developed an extensive background in research design methodologies and coverage and payment systems, as well as in social marketing and health promotion and disease prevention approaches. Jim came to CMS in 1995 and now devotes his skills and experience to conducting research demonstration projects for Medicare and Medicaid populations. Jim is the Project Officer for the Medicare Medical Home Demonstration Project.

Chad Boult, MD, MPH, MBA, is the Eugene and Mildred Lipitz Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. He directs the Roger C. Lipitz Center for Integrated Health Care and holds joint appointments on the faculties of the Johns Hopkins University Schools of Medicine and Nursing.

A geriatrician for more than 17 years, he has extensive experience in developing, testing, evaluating, and diffusing new models of health care for older persons. His current research includes Guided Care, a novel, multi-disciplinary model of primary care for older people with multiple chronic conditions. Dr. Boult is the Principal Investigator of a multi-site, cluster-randomized controlled trial of Guided Care involving 48 physicians, 933 older patients, and 319 family members in the Baltimore-Washington DC area.

Dr. Boult created the first validated instrument for identifying high-risk older persons (the Pra) and co-edited a book entitled "New Ways to Care for Older People: Building Systems Based on Evidence: Springer Publishing Company, 1999." He received the Excellence in Research Award from the American Geriatrics Society in 2000. From 2000-2005 he edited the "Models and Systems of Geriatric Care" Section of the Journal of the American Geriatrics Society.

Barbara A. Walters, DO, MBA, Senior Medical Director for Dartmouth-Hitchcock's Southern New Hampshire Community Group Practices, is responsible for the management of ambulatory practice operations located in 15 locations, employing 1,200 employees, 300 providers, and providing 1,000,000 visits per year. In addition she is responsible for commercial payor contracting for the Dartmouth-Hitchcock system and is the principal investigator for the CMS PGP Demonstration Project. Board certified in psychiatry and neurology, Dr. Walters came to Dartmouth-Hitchcock in 1998 from the Carolina Permanente Medical Group in Chapel Hill, North Carolina, with extensive experience in group practice and managed care.

Hospital to Home:
Improving Quality and Savings Through Innovative Transitional Care

May 12, 2010

Mary Naylor, PhD, RN, FAAN
Director of the New Courtland Center for Transitions and Health, University of Pennsylvania School of Nursing

Denise Levis Hewson, BSN, MSPH, RN
Director of Clinical Programs and Quality Improvement, Community Care of North Carolina

Scott Mader, MD
Clinical Director, Rehabilitation and Long Term Care Division Portland VA Medical Center

Laurel Sweeney, Moderator
Senior Director, Global Reimbursement Policy, Philips Healthcare

To view the webinar visit:
http://www.healthcare.philips.com/us_en/support/Reimbursement/Education/archive.wpd

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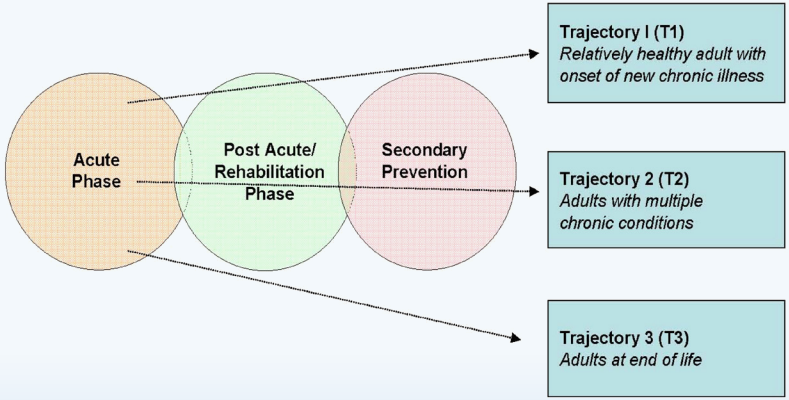
WEBINAR OVERVIEW

This webinar taps into one of the powerful new provisions of the just-enacted health reform bill. That is, reducing readmissions through better care coordination and management across care settings. It featured leaders from the field who shared their experience and insight in applying this approach with Medicaid and Medicare patients, chronic disease patients, and in a Veterans Administration hospital.

Mary Naylor *makes the case for and defines transitional care as follows:*

Transitional Care–range of time limited services and environments that compliment primary care and are designed to ensure health care continuity and avoid preventable poor outcomes among at risk populations as they move from one level of care to another, among multiple providers and across settings.



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Why Transitional Care is Needed - Making the Case

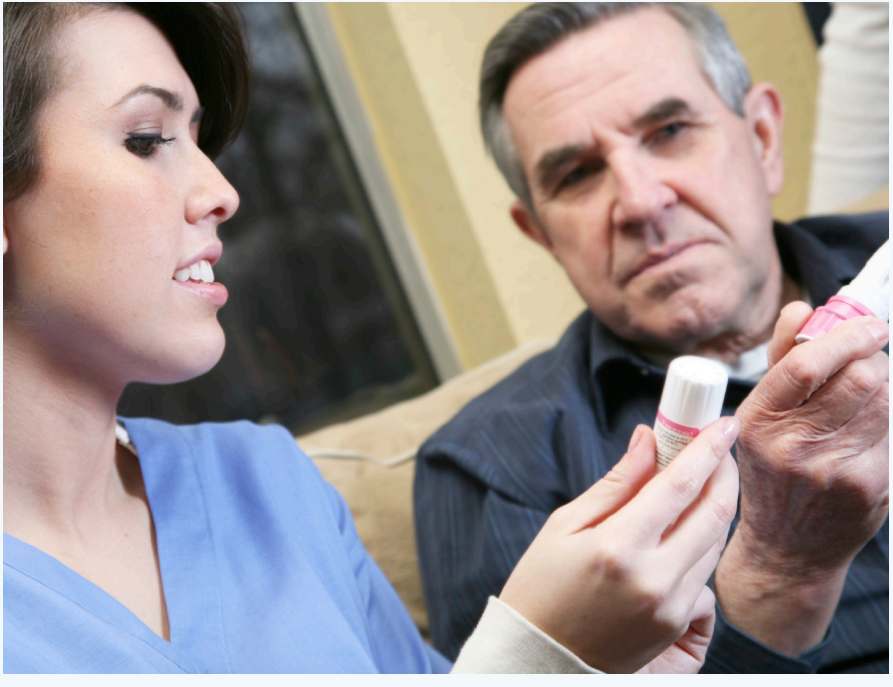
- High rates of medical errors
- Serious unmet needs
- Poor satisfaction with care
- High rates of preventable readmissions
- Tremendous human and cost burden

Core Components

- Holistic, person/family centered approach
- Nurse-led, team model
- Protocol guided, streamlined care
- Single "point person" across episode of care
- Information/communication systems that span settings

Unique Features: Care is Delivered and Coordinated

- By same advanced practice nurse
- In hospitals, SNFs, and homes
- Seven days per week
- Using evidence-based protocol
- With focus on long term outcomes



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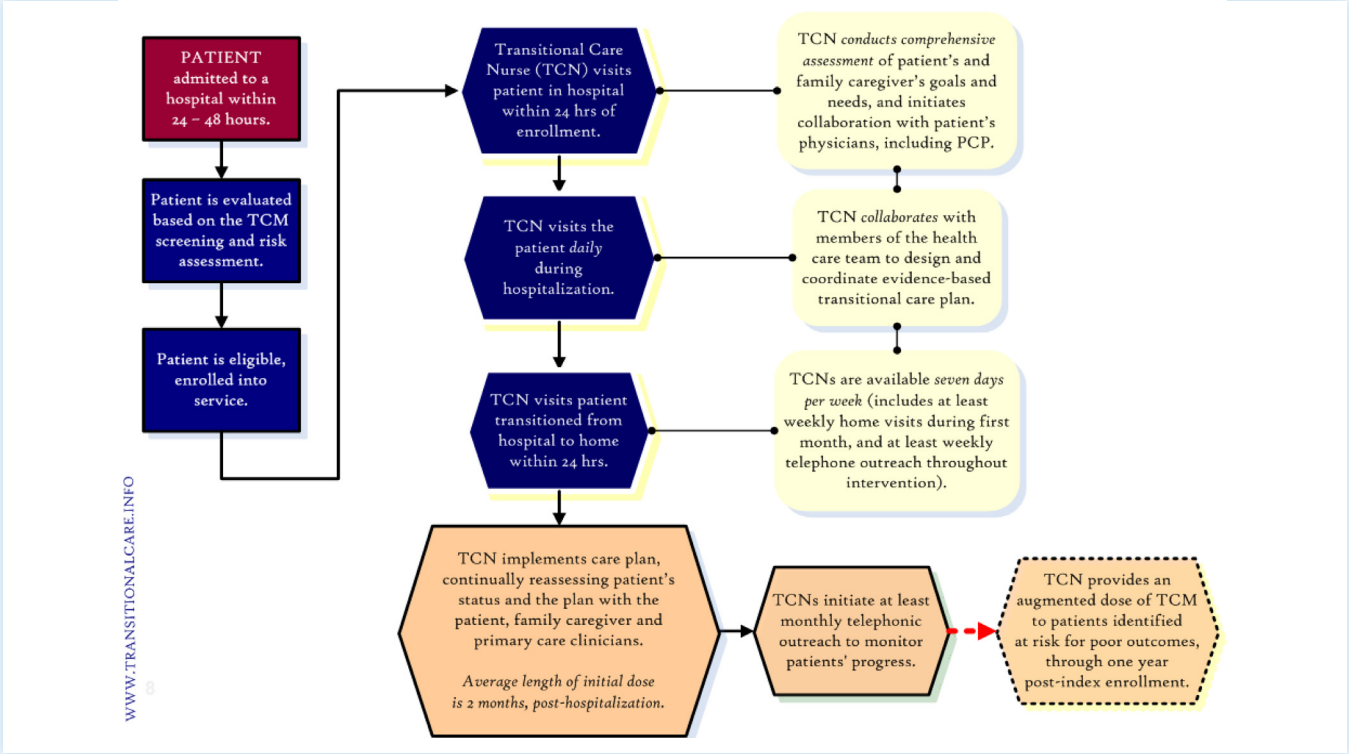
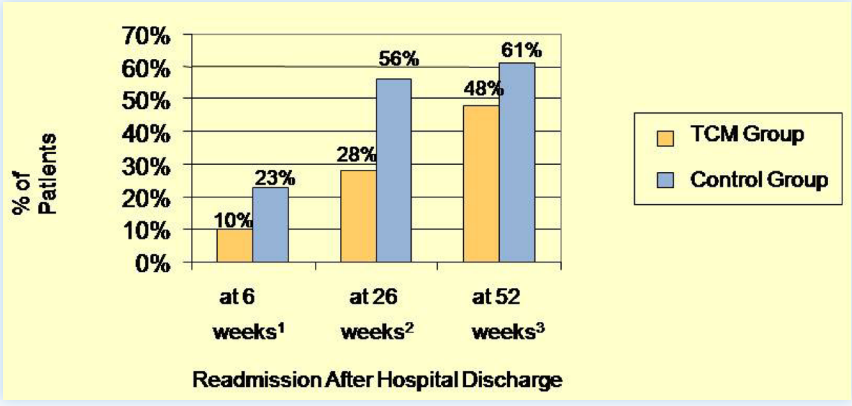
▼ Transitional care model - protocol overview



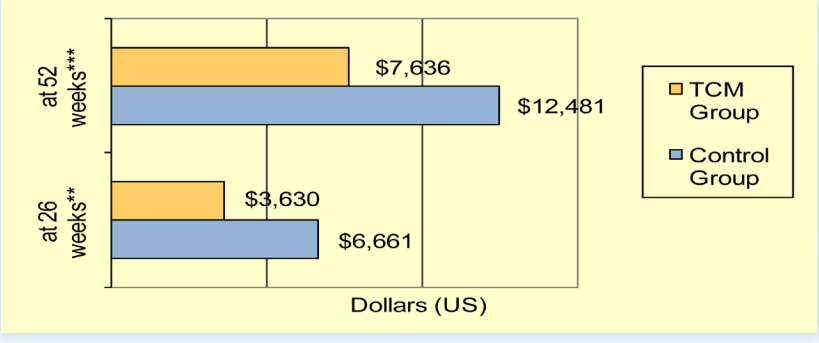
▼ TCM's impact on readmission rates after index hospitalization



Successes across randomized controlled trials, transitional care has

- Increased time to first readmission or death
- Improved physical function and quality of life
- Increased patient satisfaction
- Decreased total all-cause readmissions
- Decreased total health care costs

TCM's impact on total health care costs ▼



Barriers to Widespread Adoption

- Organization of current system of care
- Regulatory barriers
- Lack of quality and financial incentives
- Culture of care

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Denise Levis Hewson, *provided another example of how to improve quality and savings through an innovative model of transitional care:*

Community Care of North Carolina

- Joins other community providers (hospitals, health departments and departments of social services) with primary care physicians
- Designated primary care medical home
- Creates community networks that assume responsibility for managing recipient care in concert with medical homes

Community Care has been able to

- Forge links with all the hospitals, getting timely information about hospitalized enrollees
- Visit patients in the hospital, when possible
- Conduct follow-up home visits to perform medication reconciliation and self-management support
- Build relationships and share information with community providers (health care team)
- Designate care managers as the conduit for information exchange

Best Practices and Early Results

- All networks are getting "real time" data from hospitals
- Embedded care managers in the large tertiary hospitals
- Embedded care managers in practices with large numbers of aged, blind and disabled (high cost and high risk)
- Most recent data shows an 8% reduction in 30 day re-admission rates

***Scott Mader**, discussed two examples of home hospital care: Project @ Home (a study of care for older people) and Program @ Home (an alternative to hospitalization):*

Why develop a Home Hospital?

- Hospital can be a difficult environment for older persons
- Demographics
- Economics
- Local-Portland VA bed shortage
- Support and vision from John A Hartford Foundation/Johns Hopkins/VA New Clinical Initiatives

Project @ Home …A Study Of Care For Older Persons

The model

- Patients 65 and older who would otherwise require hospital admission for specific diagnoses (CHF, COPD, Cellulitis, CAP)
- A period of continuous nursing followed by twice daily RN visits
- Daily MD visits

Summary of Outcomes

- Acceptable model for older persons/caregivers
  - 60% chose care at home if offered
- Clinical safety of Home Hospital care
  - Decreased delirium rates, sedative use, bowel cx
- Satisfaction of patients & caregivers
  - Higher for points and caregivers than hospital care
  - Overall stress levels lower
- Costs of care in Home Hospital vs acute hospital
  - Costs lower
- Feasibility of Home Hospital model in integrated health system
  - Implementation was difficult
  - Recruitment lower than expected

Transition from Project @ Home to Program @ Home

- Portland VA had funds for transition to a non-research model
- Feedback from our users
  - Patients/families
  - Emergency Room
  - Inpatient teams
  - Primary care
- Home Hospital MDs
- Home Care Program

Program @ Home…
An Alternative to Hospitalization

- Modified program treated the same diagnosis (CHF, COPD, CAP, cellulitis), but:
  - Accept patients of all ages
  - Accept early hospital discharges (now about 75%)
  - Provide a single daily RN visit
  - Provide a one-time MD visit with daily MD oversight
  - Sometimes accept for the next day
- Admit patients 8 AM – 4:30 PM, 7 days/week
  - Ability to manage late admissions the following day
- Daily skilled RN visits
- 24/7 MD oversight and coverage
  - One MD home visit, and others as needed
  - Private answering service
- Medical equipment
  - Nebulizers, Oxygen
  - Prepaid cell phone (Lifeline-not used)
- Medical Services
  - IV medication (qd antibiotics, diuretics)
  - In-home lab draws and specimen delivery ($40K/year)
  - Patient transport to and from hospital if needed
  - Bladder US
  - In-home X-Ray and EKG available (rarely used)

Estimated Benefits

- Decreases hospital divert time/adds acute care capacity
- Saves 300+ bed-days-of-care and ECU visits/revisits
- Allows 7 day/week homecare program for staff and patients
- Supports ECU, inpatient, and primary care programs
- Patient satisfaction/excellence in patient care
- Slight direct cost savings: 300 BDOC @ $1700/BDOC = $510K vs $400K
- VA incentive for non-institutional care

PHILIPS

PRESENTER BIOS

Mary D. Naylor, PhD, RN, FAAN, is the Marian S. Ware Professor in Gerontology and Director of the New Courtland Center for Transitions and Health at the University of Pennsylvania, School of Nursing. Since 1990, Dr. Naylor has led a multidisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations and reduce health care costs for vulnerable, community-based elders.

Dr. Naylor is the National Program Director for the Robert Wood Johnson Foundation sponsored Interdisciplinary Nursing Quality Research Initiative. She was elected to the National Academy of Sciences, Institute of Medicine (IOM) in 2005. She also is a member of the RAND Health Board, the National Quality Forum Board of Directors and Chair of the recently established Long Term Quality Alliance.

Denise Levis Hewson, BSN, MSPH, RN, received her Bachelors of Nursing and Masters of Science in Public Health from the University of North Carolina in Chapel Hill and has spent most of her career researching, developing and implementing community based medical home initiatives targeting vulnerable populations. Denise has been involved in North Carolina's Medicaid initiatives since the mid 80s and has consulted with other states as they explored opportunities to better manage and improve the quality of health care delivered to their target populations. She is the Director of Clinical Programs and Quality Improvement for Community Care of North Carolina – a Medicaid "medical home" program serving over 1 million enrollees through 14 participating community based networks with over 1350 practices and 3500 primary care providers. Denise has consulted with many states and organizations on quality improvement, practice re-design, enhanced medical home, chronic care model, care and disease management, data and health informatics, system delivery re-design and population management.

Scott Mader, MD, is the Clinical Director of the Rehabilitation and Long Term Care Division at the Portland VA Medical Center, and a Professor of Medicine at Oregon Health & Science University.

He received his medical degree from Case Western Reserve University in Cleveland, Ohio. He did internal medicine training at Strong Memorial Hospital in Rochester in NY, and Geriatric Fellowship training in Los Angeles at the UCLA/VA Medical Centers. In addition to his interest and clinical work in Home Hospital Care, he is an active, practicing geriatrician and has additional research programs in orthostatic hypotension and age-related changes in blood vessel relaxation.

PHILIPS

Appendix: The Philips Healthcare "Reimbursement Simplified" Webinar Series

Quality, Health Reform and the Bottom Line: How Quality-focused Payment Changes under Health Reform will Affect Hospitals
October 27, 2010
View the complete slide set:
http://www.healthcare.philips.com/pwc_hc/us_en/support/Reimbursement/Docs/Webinars/Webinar_oct272010.pdf
Listen to the webcast: http://vmx.highroadsolution.com/se/Meetings/Playback.aspx?meeting.id=253354

Improving Quality and Savings Through Innovative Transition Care
May 12, 2010
View the complete slide set:
http://www.healthcare.philips.com/pwc_hc/us_en/support/Reimbursement/Docs/Webinars/Webinar_may122010.pdf
Listen to the webcast: http://www.visualwebcaster.com/event.asp?id=67845

Reimbursement and Quality under Health Reform
January 28, 2010
View the complete slide:
http://www.healthcare.philips.com/pwc_hc/us_en/support/Reimbursement/Docs/Webinars/Webinar_28jan2010_slides.pdf
Listen to the webcast: http://www.visualwebcaster.com/event.asp?id=64566

Global Payments: Panacea for Payment Reform?
July 29, 2009
View the complete slide set:
http://www.healthcare.philips.com/pwc_hc/main/shared/Assets/Documents/Reimbursement/July29_2009global_payments_webinar.pdf
Listen to the webcast: http://www.visualwebcaster.com/PhilipsHealthcare/60105/reg.html

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Health Reform: Moving from Talk to Action
May 5, 2009
View the complete slide set:
http://www.healthcare.philips.com/pwc_hc/us_en/about/assets/Docs/reimbursement/webinars/SlidesPhilips4May2009health_reform_webinar.pdf

The Medical Home: A Model for Health Reform?
February 17, 2009
View the complete slide set:
http://www.healthcare.philips.com/pwc_hc/main/shared/Assets/Documents/Reimbursement/webinar_17022009.pdf
Listen to the webcast: http://www.visualwebcaster.com/PhilipsHealthcare/55014/reg.html

Accreditation and Appropriateness Provisions of the Medicare Improvements for Patients and Providers Act of 2008
October 14, 2008
View the complete slide set:
http://www.healthcare.philips.com/pwc_hc/us_en/about/assets/Docs/reimbursement/Philips_webinar_2008-10-14.pdf
Listen to the webcast:
http://www.visualwebcaster.com/vwp/player/advplayer.html?id=51406&uid=2401562&time=geemfefjeefkgm&digest=r8nyagsyxeizpbvkhxlsnw

Value-Based Purchasing and the Hospital's Bottom Line
June 23, 2008
View the complete slide set: http://www.healthcare.philips.com/us_en/about/Reimbursement/events/archive.wpd
Listen to the webcast: http://www.visualwebcaster.com/PhilipsHealthcare/51406/reg.html

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